HOW AM I DOING?
YOUR CHILD 12 MONTHS THROUGH 6 YEARS
RISK ASSESSMENT

If you have any questions or concerns about yourself or your child, please share these with your child’s health care provider. We want to assist you with your needs anyway possible.

YES NO

1. Has your child had contact with person with confirmed or suspected infectious tuberculosis. (Family member or associate in jail or prison)

2. Has your child had an x-ray or examination that may suggest tuberculosis?

3. Has your child emigrated from a foreign country where there is a history of tuberculosis? (Asia, Middle East, Africa, Latin America)

4. Has your child traveled to a foreign country or had contact with a native person from such a country where there is a history of tuberculosis?

5. Does your child have HIV/AIDS?

6. Has your child or does your child live in a group home, foster care, or orphanage?

7. Are you concerned that someone will harm you or your child, or worry that you will harm someone?

8. Has your partner or someone important to you emotionally, physically, or sexually abused you or your child?

9. Does your child ever threaten to harm him/herself?

10. Does your child live in or visit a house with peeling or chipping paint built before 1950? (Daycare, preschool, baby-sitter, or relative, etc.)

11. Does your child live in or visit a house built before 1978 with recent, ongoing, or planned renovations or remodeling?

12. Does your child have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (blood level at or above 20ug/dl)?

13. Does your child live with an adult whose job or hobby involves exposure to lead? (Lead batteries, firing range, chemicals & chemical preparations, bridge, tunnel, elevated highway construction, etc.)

14. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?

15. Have you seen your child eating paint chips or dirt? Chew on any painted surfaces?

16. Do you or the child’s parents do migrant farm work?

17. Does your child receive any home or folk remedies that may contain lead?

18. What type of water does your child drink daily? (Circle all that apply for your child):

   City       Well       Cistern       Bottled Water
19. Does your child do or attempt to (circle those that apply under age of your child):

<table>
<thead>
<tr>
<th>12 MO.</th>
<th>15 MO.</th>
<th>18 MO.</th>
<th>24 MO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cruise (walk or crawl)</td>
<td>Walk Well</td>
<td>Run Stiffly</td>
<td>Climb Up &amp; Down Stairs</td>
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<tr>
<td>Pull to Stand</td>
<td>Climb</td>
<td>Roll a Ball</td>
<td>Kick a Ball Forward</td>
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<tr>
<td>Take Steps</td>
<td>Stack 2 Blocks</td>
<td>Scribble</td>
<td>Circular Crayon Strokes</td>
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<tr>
<td>Bang Blocks Together</td>
<td>Speak 3 to 6 words</td>
<td>Mimic Words</td>
<td>Stack 5-6 Blocks</td>
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<tr>
<td>Imitate Sounds</td>
<td>Speak in 2 Word Phrases</td>
<td>Name Objects</td>
<td>Use 2-3 Word Phrases</td>
</tr>
<tr>
<td>Say “Bye” &amp; “No”</td>
<td>Listen to Story</td>
<td>Speak 15 – 20 Words</td>
<td>Follow 2-Step Commands</td>
</tr>
<tr>
<td>Play Pat-a-cake</td>
<td>Use a Cup</td>
<td>Blow Kisses</td>
<td>Imitate Adults</td>
</tr>
<tr>
<td>Wave Bye-Bye</td>
<td>Make Gestures (point, shake head)</td>
<td>Use Spoon/Fork</td>
<td>Remove Clothes</td>
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<table>
<thead>
<tr>
<th>3 YR.</th>
<th>4 YR.</th>
<th>5 YR.</th>
<th>6 YR.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jump Up &amp; Down</td>
<td>Hop on 1 Foot</td>
<td>Skip</td>
<td>Heel to Toe Steps</td>
</tr>
<tr>
<td>Throw Ball</td>
<td>Throw Overhand</td>
<td>Balance on 1 foot 5 sec.</td>
<td>Draw 6 Part Man</td>
</tr>
<tr>
<td>Copy Circles &amp; Crosses</td>
<td>Wiggle his/her Thumb</td>
<td>Draws 3 Part Man</td>
<td>Know All Letters of the Alphabet</td>
</tr>
<tr>
<td>Know Name, Age, &amp; Sex</td>
<td>Sing Songs</td>
<td>Knows Address &amp; Phone</td>
<td>Count Numbers</td>
</tr>
<tr>
<td>Use 3-4 Word Phrases</td>
<td>Be aware of Self/Others</td>
<td>Dresses Without Help</td>
<td>Understand Right/Wrong</td>
</tr>
</tbody>
</table>

YES  NO

20. Do you have concerns about your child’s weight or eating habits?
21. Does your child follow a special diet or is on a prescribed medication?
22. Does your child eat or drink every day: (circle all that apply)
   - Fried Foods
   - Lunch Meats
   - Soft Drinks
   - Cake
   - Cookies
   - Chips

23. Does your child eat 6 servings of any of the following daily: bread, cereal, rice, or pasta?
24. Does your child eat 3 servings of vegetables each day?
25. Does your child eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?
26. Does your child eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup, beans, eggs or peanut butter?
27. Does your child eat or drink 3 servings daily of any of the following: milk, cheese or yogurt?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

ENTIRE FORM HAS BEEN REVIEWED AND UPDATE WITH PATIENT ON FOLLOWING DATES:
(SIGNATURE AND DATE REQUIRED)


ACH-91 (9/98)